Flexible Benefit Plan
Election/Change Form

Employee Name (first, middle, last)			Social Security Number	Day-time Telephone Number
Mailing Address (include city, state, zip)			E-mail address	
Dept. Name	DOB	Date of Hire	Effective Date	First Payroll Deduction Date

ACTION	REASON FOR ACTION	Date the Family Status Change Occurred:_____
❑ enroll ❑ change to existing election	❑ new hire ❑ termination ❑ marriage ❑ birth/adoption	❑ divorce ❑ legal separation/annulment ❑ death of spouse/dependent ❑ employment began/terminated for spouse/dependent	❑ increase/reduction in hours by employee/spouse/dependent ❑ unpaid leave of absence ❑ entitlement to medicare/medicaid ❑ other_____

BENEFITS

I hereby authorize and direct my employer to reduce my salary by the amount(s) indicated in each reimbursement account stated below.

Health Care Reimbursement (plan maximum amount is $5,000)

❑ Yes, I want to participate. The amount I wish to have deducted per pay period is $_____ which is a total of $_____for the plan year.

❑ No, I do not wish to participate.

Dependent Care Assistance (plan maximum amount is $5,000 married filing jointly; $2,500 married filing separately; or the earned income limitation)

❑ Yes, I want to participate. The amount I wish to have deducted per pay period is $_____ which is a total of $_____for the plan year.

❑ No, I do not wish to participate.

(And, $_____ will be deducted from payroll in equal installments for the fees associated with the reimbursement account for a total plan year cost of $_____)

DISCLOSURE STATEMENT

I understand that my election and participation made herein is voluntary and that I cannot disenroll during the plan year, and may be changed only as of July 1 of each year or in the event of a change in family status. The Health Care Reimbursement account only allows increases for the family status changes; no mid-plan year reductions are permitted. The requested change must be submitted within 31 days of family status change to the HR Insurance/Benefits Division. Furthermore, I am aware that my expenses paid through the pre-tax benefit plans are no longer eligible for credits under the federal or state income tax purposes.

I understand that any amounts remaining in my account(s) at the end of the plan year (including the 90 days grace period), that are not used for eligible expenses incurred during the plan year, will be forfeited in accordance with current plan provisions and tax laws. I further understand that if I terminate employment during the plan year, I will have 90 days from date of termination to submit claims incurred while a participant. After 90 days, I forfeit any account balance.

Authorization: I certify the above information to be correct and true and any dependents for which I have selected reimbursement benefits reside with me and/or are legally dependent on me (based on IRS regulations) for their support. 100 percent of the premiums for the spending accounts are my responsibility.

_____ _____

Participant's Signature & Date **Representative's Signature & Date**

Direct Deposit Authorization

B.A.S.I.C.FLEX Cafeteria Plan

Please print:

Employer Name: _____

Employee Name: _____

Employee Social Security Number: _____

Internet E-Mail Address: _____

Please direct deposit my Medical and/or Dependent Care Reimbursement into the following:
Select one: Checking Account ❑ or Savings Account ❑

Financial Institution:_____

You MUST attach a voided check for the account into which you are directing the deposits. (Deposit slips are not acceptable.) Direct deposits will begin approximately 2 weeks after we receive this information from your employer.

I understand that **ALL** reimbursements will be direct deposited into my account. My commitment to direct deposit is for the entire plan year.

Employee Signature: _____ Date:_____

Please tape voided check in this space.